Bureau Of Emergency Medical Services/Trauma Program
150 N. 18th Avenue, Suite 540, Phoenix, Arizona 85007-3248; 602-364-3150

APPLICATION FOR TRAUMA CENTER DESIGNATION

A.R.S. Title 36, Chapter 21.1 and A.A.C. Title 9, Chapter 25

☐ **INITIAL DESIGNATION** ☐ **RENEWAL DESIGNATION**

I. HEALTH CARE INSTITUTION INFORMATION

Name of Health Care Institution		
Address		
City	State	Zip Code
Main Telephone Number	Health Care Institution's AZ License Number (if applicable)	

I.A. U.S. GOVERNMENT AGENCY/SOVEREIGN TRIBAL NATION INFORMATION (if applicable)

☐ Administrative Unit of the U.S. Government (*specify*):			
☐ Administrative Unit of a Sovereign Tribal Nation (*specify*):			
Address			
City	County	State	Zip Code
Main Telephone Number			

II. OWNER INFORMATION (As defined in R9-25-1301)

Owner's Name		
Address		
City	State	Zip Code
Telephone Number	Fax Number (if available)	E-mail Address (if available)

III. DESIGNATION AND VERIFICATION INFORMATION

Designation Level for which applying	Level I ☐	Level II ☐	Level III☐	Level IV☐
Does the health care institution hold American College of Surgeons Committee on Trauma (ACS) Verification? Yes ☐ No ☐				
If yes, at what Level?	Level I ☐	Level II ☐	Level III☐	Level IV☐
Effective Date of ACS Verification	Expiration Date of ACS Verification			

IV. ELIGIBILITY FOR DESIGNATION (Eligibility for designation based on)

☐ ACS Verification
☐ Meets the state standards in Exhibit I
☐ Eligibility for the grace period under A.A.C. R9-25-1303

V. TRAUMA MEDICAL DIRECTOR (Required if applying for designation as a Level I, II, or III trauma center)

Name	Telephone Number
E-mail Address (if available)	Fax Number (if available)

VI. CHIEF ADMINISTRATIVE OFFICER FOR HEALTH CARE INSTITUTION

Name	Telephone Number
E-mail Address (if available)	Fax Number (if available)

VII. STATUTORY AGENT (or individual designated to accept service of process and subpoenas)

Name	Title
Address	Telephone Number

VIII. ATTACHMENTS (Attach the following, as applicable)

INITIAL APPLICATION

☐ A copy of the current regular health care institution license issued by the Department, if applicable

☐ If applying for designation based on ACS Verification, documentation issued by ACS establishing current ACS Verification at the Level of designation sought and showing the effective and expiration dates of the ACS Verification

☐ If applying for designation as a Level I, II, or III trauma center based on meeting the state standards in Exhibit I, current documentation issued by ACS establishing that the health care institution meets the state standards in Exhibit I for the Level of designation sought

RENEWAL APPLICATION

☐ If applying for renewal of designation as a Level I, II, or III trauma center based on meeting the state standards in Exhibit I, one of the following:

a. Documentation issued by ACS no more than 60 days before the date of application establishing that the trauma center meets the state standards in Exhibit I for the Level of designation sought; or

b. Documentation issued by ACS establishing that the Owner has applied for ACS Verification for the trauma center, at the Level corresponding to the Level of designation sought, for the three-year period directly following the expiration of the Owner's current state designation

☐ If applying for renewal of designation as a Level I, II, or III trauma center based on ACS Verification, documentation issued by ACS establishing that the Owner:

a. Holds ACS Verification for the trauma center, at the Level corresponding to the Level of designation sought, for the three-year period directly following the expiration of the Owner's current ACS Verification and state designation; or

b. Has applied for ACS Verification for the trauma center, at the Level corresponding to the Level of designation sought, for the three-year period directly following the expiration of the Owner's current ACS Verification and state designation

☐ If applying for renewal of designation as a Level IV trauma center, based on meeting the state standards in Exhibit I, completion of this application containing all information listed in R9-25-1304(A)(1)

IX. ATTESTATION

According to A.A.C. R9-25-1304, the application must be signed as follows:

(1) If the Owner is an individual, by the individual;
(2) If the Owner is a corporation, by an officer of the corporation;
(3) If the Owner is a partnership, by one of the partners;
(4) If the Owner is a limited liability company, by a manager or, if the limited liability company does not have a manager, a member of the limited liability company;
(5) If the Owner is an association or cooperative, by a member of the governing board of the association or cooperative;
(6) If the Owner is a joint venture, by one of the individuals signing the joint venture agreement;

(7) If the Owner is a governmental agency, by the individual in the senior leadership position with the agency or an individual designated in writing by that individual; and
(8) If the Owner is a business organization type other than those described in (2) through (6) above, by an individual who is a member of the business organization.

On behalf of the Owner, I attest that the Owner knows all applicable requirements in A.R.S. Title 36, Chapter 21.1 and A.A.C. Title 9, Chapter 25, Article 13, and that the information provided in this application, including the information in the documents attached to this application form, is accurate and complete.

Additionally, for the Owner applying for designation based upon eligibility under A.A.C. R9-25-1303, on behalf of the Owner, I attest that the Owner's health care institution will meet the state standards for one of the following selected trauma center designation Levels during the initial designation period:

☐ **Level I trauma center**
☐ **Level II trauma center.**

_____ _____
Signature Date

_____ _____
Name (Printed) Title

See Page 4 for Instructions on Completing the Application

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR TRAUMA CENTER DESIGNATION

(Please type or print in black ink in completing this application)

SELECT THE BOX AT THE TOP OF THE APPLICATION TO INDICATE IF YOUR APPLYING FOR AN INITIAL OR A RENEWAL DESIGNATION

SECTION I. HEALTH CARE INSTITUTION INFORMATION

Name of Health Care Institution: Please enter the complete name of your facility. If applicable, enter the name as it appears on your current Arizona facility license. The name entered on this line of the application will be the name that appears on your trauma center designation certificate.

Address information: Please enter the street address where the facility is located.

Main Telephone Number: Please enter the telephone number that the general public uses in contacting your facility.

Health Care Institution AZ License Number: If applicable, please enter the number of your current Arizona facility license.

SECTION I.A. U.S. GOVERNMENT AGENCY/SOVEREIGN TRIBAL NATION INFORMATION

This section only applies if your health care institution is an administrative agent of the U.S. government or are a sovereign tribal nation operating the health care institution as a hospital under federal or tribal law. If this section applies, select the appropriate option.

Address information: Please enter the street address where the owner is located.

Main Telephone Number: Please enter the telephone that the general public uses in contacting your facility.

SECTION II. OWNER INFORMATION.

Owner's Name: Please enter a response that corresponds with the applicable option comprising the definition of "Owner" in A.A.C. R9-25-1301(25).

Address information: Please enter the street address where the owner is located.

Telephone Number/Fax Number/Email Address: Please enter the information for each contact medium that will allow the Department to directly contact the owner.

SECTION III. DESIGNATION AND VERIFICATION INFORMATION.

Designation Level for Which Applying: Please be sure to review the trauma center designation rules carefully when selecting the Level of trauma center designation for which you are applying. You can download a copy of the rules at the following Department website: http://www.azdhs.gov/bems/trauma.htm

Does the Health Care Institution Hold ACS Verification? Please indicate whether your health care institution holds **current** ACS verification for the applicable trauma center Level.

Effective Date of ACS Verification: The effective date of ACS verification should be the date of your verification letter issued by the ACS.

Expiration Date of ACS Verification: The expiration date of ACS verification should be three (3) years from your verification effective date.

SECTION IV. ELIGIBILITY FOR DESIGNATION.

Please select the one option that identifies the basis for your eligibility for trauma center designation.

SECTION V. TRAUMA MEDICAL DIRECTOR

Completion of this section is only required for applicants seeking Level I, II, or III trauma center designation.

SECTION VI. CHIEF ADMINISTRATIVE OFFICER FOR HEALTH CARE INSTITUTION

Please enter a response that corresponds with the definition of "Chief administrative officer" (CAO) in A.A.C. R9-25-1301(6).

Address information: Please enter the street address where the CAO is located.

Telephone Number/Fax Number/Email Address: Please enter the information for each contact medium that will allow the Department to directly contact the CAO.

SECTION VII. STATUTORY AGENT

Please enter the name, title, address, and telephone number of the individual who is designated to accept service of process and subpoenas for your health care institution.

Pleas submit this application with all applicable documents and information as required in rule. If you do not have Internet access, please contact the Bureau of Emergency Medical Services at the telephone number listed below and a copy of the rules will be sent to you.

This application is not considered completed until all required documents and information have been submitted to the Department. If any corrections are made using correction fluid or correction tape, this application will be returned. If an error is made while filling out this application, put a single line through the error with your initials. Please remit the completed application to:

Arizona Department of Health Services
Bureau of Emergency Medical Services
150 N. 18th. Avenue, Suite 540,
Phoenix, Arizona 85007
(602) 364-3158 or 1-800-200-8523